

Perspectives for Italian Psychiatry

Prospettive per la psichiatria italiana

Psychiatry is facing a constant increase of services demands from the population. From one side the improvement of life conditions facilitates the emergence of psychopathology that affects about 50% of the population lifetime¹, from the other psychiatrists often serve as an emergency care in social needs (such as homeless or unemployed) where the psychiatric component is marginal if any. This leads to a demand of care from a very large part of the population with consequences that we will analyze and discuss throughout the editorial.

Specifically, in Italy, after more than 30 years of the dramatic change occurred in psychiatry services organization, such aspects impact even more with a generalized dissatisfaction both for patients and staff members, though with some local exceptions^{2,3}. The 1978 change in the whole body of regulations defining psychiatric activity completely reversed the role of the psychiatrist from a figure mainly devoted to social control (as specified in the 1904 law) to a figure promoting patient autonomy. However both aspects are still present and the psychiatrist faces in the everyday clinical practice this dilemma: benefit of the patient vs. benefit of the social context. Further, the huge demand of care by the population faces a relatively insufficient offer from psychiatric services further impaired by a large heterogeneity in the specific models of care (inpatients vs outpatients, drugs vs. psychosocial treatments and so on) that we will discuss later on⁴.

The diagnostic dilemma

This increase in demand is mainly due to an apparent increase of psychiatric disturbances because of the relative reduction of medical and environmental adversities, but also because of a lack of biological validators of diseases that complicate a valid nosographic identification of pathologic states⁵. Despite decades of investigations we do not have

any valid test of psychiatric disorder that has still to rely on clinical interview and observation with all the conceivable uncertainties. A further consequence of this lack of validators is the possibility of appearance of a very wide range of theoretical positions, at times based on commercial aims, at times based on ideological positions. As a result, the present status of Italian psychiatry is so heterogeneous that the same patient is likely to receive 7000 different opinions and treatments from each one of the approximately 7000 Italian psychiatrists. Clinicians behaviors may range from strict and blind adherence to international guidelines, to creative off label prescriptions, from purely pharmacologic treatments to complete absence of any drug in the treatment plan also for the most severe cases, from industry pushed prescriptions to refusal to any update and continued use of the same range of treatments for decades. Those aspects derive mainly from the authors personal experience and observation but may be also observed in some epidemiological investigation⁶. A detailed report on current Italian Psychiatric services can be found elsewhere^{7,8}.

In the need to face such a heterogeneity, approximately 30 years ago world psychiatry underwent to a change in its routine activity with the advent of the Diagnostic and Statistical Manual for Mental Disorders in its third version. For the first time a common background for formulating diagnoses was created. Despite its limitations, mainly linked to the lack of flexibility of diagnostic criteria and the lack of consideration of many aspects pertinent to the psychiatric patient, DSM success certified its importance and it is nowadays the commonly accepted diagnostic system worldwide (now at the version DSMIV-TR and together with the almost identical ICD-10 system). It is still a system based on clinical interview but its reliability is at least sufficient, in other terms out of 10 psychiatrist examining the same patient independently with

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DSMIV-TR or ICD-10, an average of 8 will agree on its diagnosis for the majority of disorders ⁹.

Unfortunately, we did not progress further than this much, and the search for biological and genetic markers for psychiatric disorders is still unsatisfactory. Regarding this point, it has been recently discussed within two major international scientific societies (American College of Neuropsychopharmacology and International Society of Psychiatric Genetics - personal communication) if we should include biomarkers in the next edition of DSM (the fifth), a consensus was reached that we do not have sufficient evidence yet and maybe we should wait some other year until DSMVI, however, for example for genetics, much evidence is being reported ¹⁰, not to mention imaging or biochemical markers ¹¹.

The social dilemma

As we previously mentioned, the lack of valid diagnoses is one important factor, but social and demographic dynamics are another important one. The improvement of quality of life other than reducing medical and environmental adversities, much prolonged life expectancy dramatically modifying the population structure in favour of elderly subjects, a trend that will continue for the next 30-40 years, leading to a marked increase of elderly typical disorder such as dementia or mixed mood abnormalities.

Furthermore, patients are more demanding now compared to decades ago, the improvement of the educational level and the easy access to medical information in the web makes at times the consultation more a confrontation. But this happens for all branches of medicine. In any case this need has to be faced, otherwise it may be a cofactor in the increasing occurrence of malpractice claims by patients, a phenomenon that psychiatrist ignored until not much time ago.

Increased knowledge leads in fact to increased expectations, the World Health Organization (WHO) definition of wellness not only as absence of disease makes patients requests closer to quest for complete recovery other than of care in the best possible way.

This model has been implemented in an optimal way in some local realities where clinicians work closely with social workers, nurses and local working facilities. In other contexts the lack of public

satisfactory health service offer, particularly for less severe cases, in Italy lead to a spread of private offer of care that raises ethical issues, as prices are not affordable by a large part of the population ¹². In fact, though the causes of mental disorders are not fully elucidated yet, a combination of biologic predisposition and factors with social and psychological influences is the most plausible cause. Therefore psychiatric care should synergically act on all those aspects for the best outcome, this also has been widely demonstrated in literature ¹³.

The knowledge of a developmental pathway for many psychiatric disorders also leads to a greater attention to childhood and adolescence. Also in this case specialized services may not always offer the right care and cases often 'spill' to adult psychiatry services such as acute adult inpatient units. In young patients, as in elderly, the boundaries of traditional diagnostic systems are frequently overwhelmed and a clear DSM diagnosis is seldom achieved. So a general 'label' of 'personality disorder' is used therefore losing the usefulness of nosography in terms of adequate treatment and prognostic expectations. This issue is further complicated by the 'environmental' impact of substance abuse, a growing factor that has been clearly associated with a worse prognosis or even with appearance of disorders that would have been latent otherwise.

Eating disorders are another relatively new product of present society, where social pressure of media models convoys latent psychopathology in full blown life threatening disorders such as anorexia nervosa. This is in fact the only psychiatric disorder more prevalent in higher socio-economic classes, therefore with increasing prevalence in the population.

Finally, the recent growth in immigrants poses a new problem, both in terms of increased pathologies in immigrants (almost double compared to their own countries ¹⁴) and in terms of different presentation of our traditional diagnostic categories. This is an aspect of increasing importance in Italian major cities but also in smaller centers.

Future care developments

Which is then the optimal care of patients? In history it heavily relied on cultural aspects, ranging from mainly religious views of mental illness ¹⁵, to philosophical positions making it a necessary

part of human life¹⁶. More recently, a positivist attitude during the late '800, promoted a biological vision culminated with the race approaches in the first half of the twentieth century that led to a rapid decline in biological researches starting from the '50. For three decades, the hegemony of the psychodynamic, phenomenological and psychosocial models^{17,18} relegated biological studies to a marginal position. The '80s, as previously stated, marked a new reverse route announced by the publication of the aforementioned DSMIII. The traditional idiographic method, that is based on the description of individual case studies, is replaced by standardized atheoretical diagnostic criteria.

For any of those cultural models treatment varied widely.

Changes in society, changes in the reference cultural model, the best treatment strategy seems therefore out of reach. The only suggestion that we are confident to give is to accept flexibility of our approach being open and receptive to a constantly changing environment.

Care of patients vs. care of students

As a concluding section, we would like to point out the impact of such events on academic activities, specifically research and teaching. Research by definition is based on scientific principles. This is not a trivial statement in a field where the complete lack of biologic validators force researchers to rely on 'words' as variables of interest. Psychometric assessments (i.e. the derivation of numerical values supposedly proxies of underlying psychological abnormalities) has been criticized by many not without reason. How can we measure depressed mood? By asking? By observing? In any case a considerable bias is introduced in the model. The mentioned idiographic approach (i.e. every person is unique and understandable only in its unique complexity) is by far the most convincing, but unfortunately it does not lead to any advance in knowledge other than teacher-pupil transmitted practical methods of care.

Therefore research must go on, and results from scientific methods and best practice investigations are tangible in terms of improved care in everyday clinical practice, particularly in the emerging fields such as adolescents and elderly persons. Nevertheless we should be open to possible 'scientific revolutions' as the classical scientific method may be

insufficient to tackle the huge complexity of events leading to mental disorders. As an example the complexity of the interaction between genes and environment and their change with time, cannot be analyzed with statistical traditional approaches also considering multivariate or flexible ones such as neural networks¹⁹. Probably even more flexible approaches as theories of Chaos or Fuzzy logic could be useful²⁰.

Teaching is another complex issue. Italy has been characterized traditionally by a prevalent cultural formation opposed to the prevalent practical training of northern Europe and US²¹. Recent directions stemming from the ministry are changing this into a prevalent practical training. Though this is reasonable (it is not possible that a psychiatrist during 4 years of training will take care 10 or less patients, as it happens at times), we should be careful not to lose the distinctive advantage of the Italian system based more on a large cultural background. An approach that in the long run brings a higher quality of care.

This apparent contradiction could be successfully faced with a more stringent combination of research activities within formation. This would educate the trainees to a cultural and critical approach even within the turmoil of everyday clinical activity, frantic as described above.

Finally, a stringent and constant evaluation of teaching and research productivity of universities is the only way to implement such suggestions.

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